# South Carolina Senate Banking and Insurance Committee

Impact of the Affordable Care Act (ACA) on Health Insurers and Their Customers

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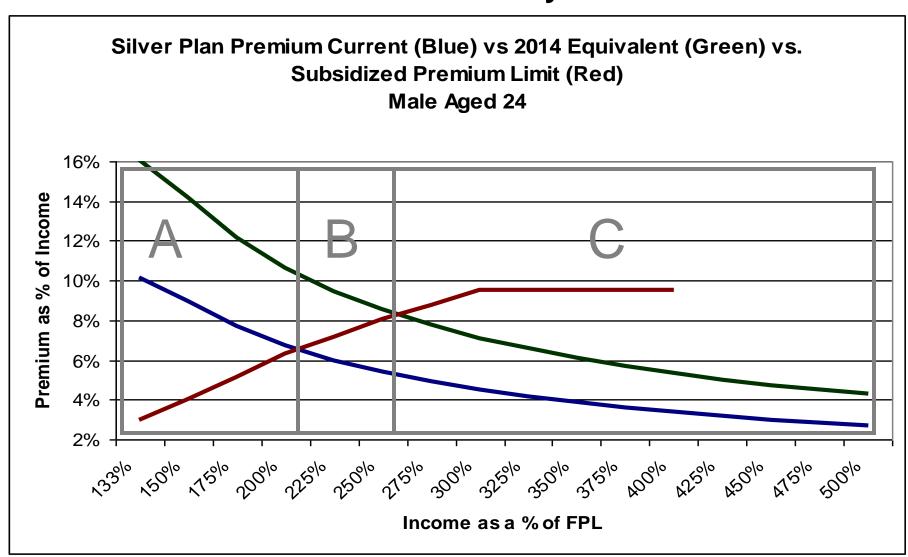
## The ACA Will Dramatically Alter the Health Insurance Marketplace and Significantly Increase Insurer Risk

- Guaranteed Issue
- Weak Mandate
- Federally Prescribed Rate Slope
- Federally Prescribed Benefits
- Changes to the ACA requirements through Federal regulation
- Exchanges
- Complete Change in Marketing Methods and Timing
- Shift of Coverage from Group to Individual and Medicaid
- Potential Influx of Some Currently Uninsured
- Federal Oversight
- Significant New Administrative Costs to Comply with Requirements but Pressure to Reduce Cost
- Federal Audits
- New Taxes/Fees
- Risk Adjusters/Risk Corridors/Mandatory Reinsurance Tremendous Complexity
- Very Little, if Anything, to Control Healthcare Cost

# The ACA Will Also Have a Negative Impact on Individuals In South Carolina

- Premiums will be higher
- Product choices will be limited
- Annual product changes may be required
- Even with an Exchange, individuals will encounter some complexity and uncertainty due to the operation of premium and benefit subsidies
- Some employers will have a financial incentive to drop coverage for their employees

## Post 2014 ACA Impact on Individual Premiums After Subsidy

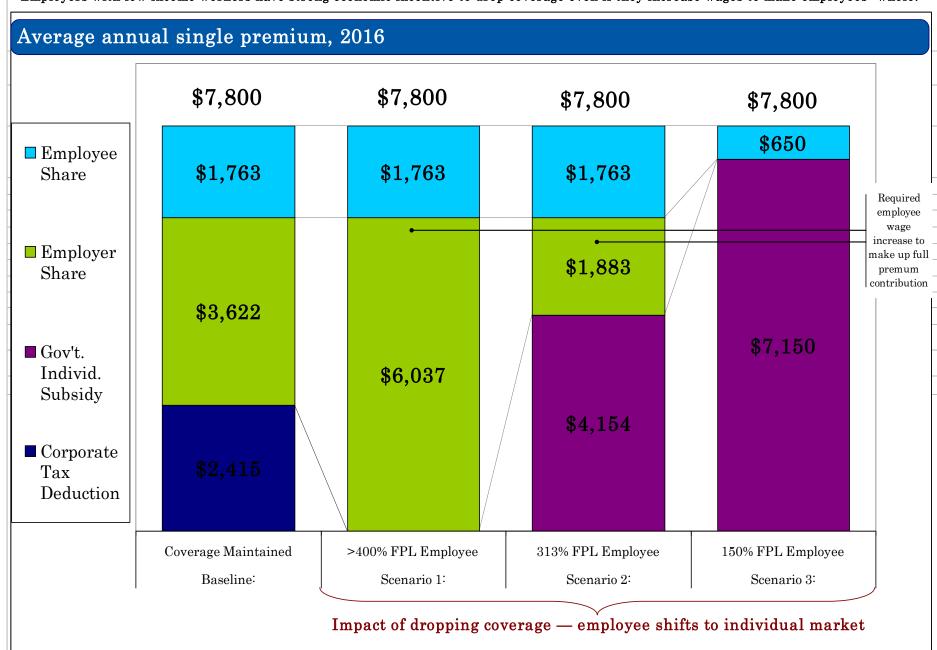


## Post 2014 ACA Impact on Individual Premiums After Subsidy

- Area A: Individuals who will pay less than the premium for the equivalent benefit today as a result of the Federal subsidy – in this example, individuals between 133% and 200% of FPL
- Area B: Individuals who are eligible for a subsidy but whose premium will be greater than the premium for the equivalent benefit today even after the Federal subsidy – in this example, individuals between 200% and 250% of FPL
- Area C: Individuals who will not receive a subsidy and whose premium will be greater than the premium for the equivalent benefit today – in this example, individuals above 250% of FPL

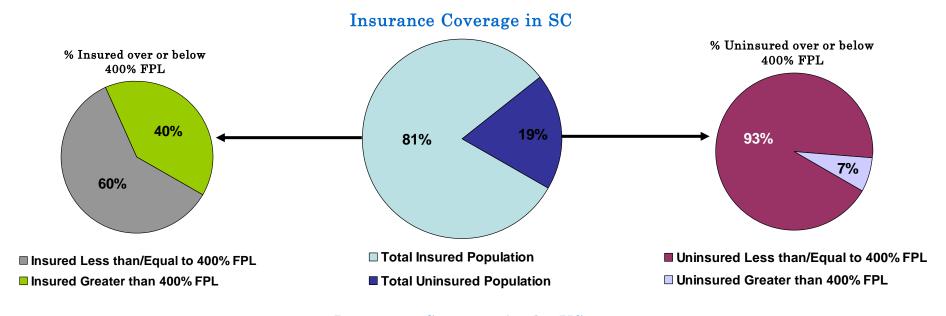
#### Impact of Eliminating Coverage for Low Income Workers

Employers with low income workers have strong economic incentive to drop coverage even if they increase wages to make employees "whole."

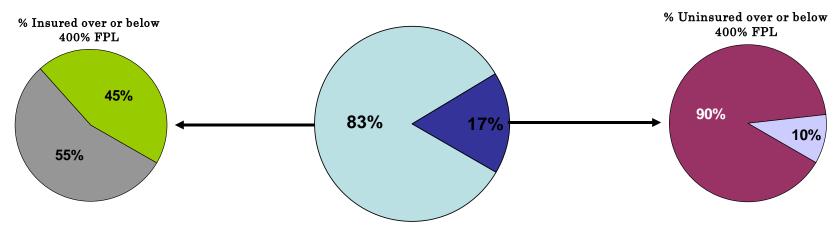


## Appendix

#### Insurance Coverage in SC and the US

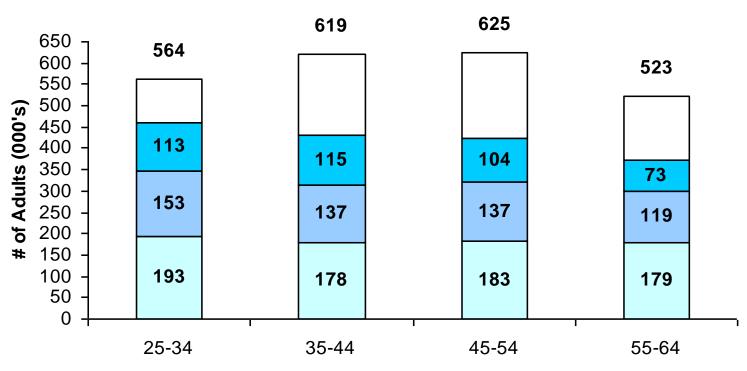


Insurance Coverage in the US

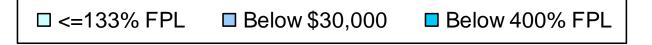


**Source**: Kaiser State Health Facts, 2007-'08 data

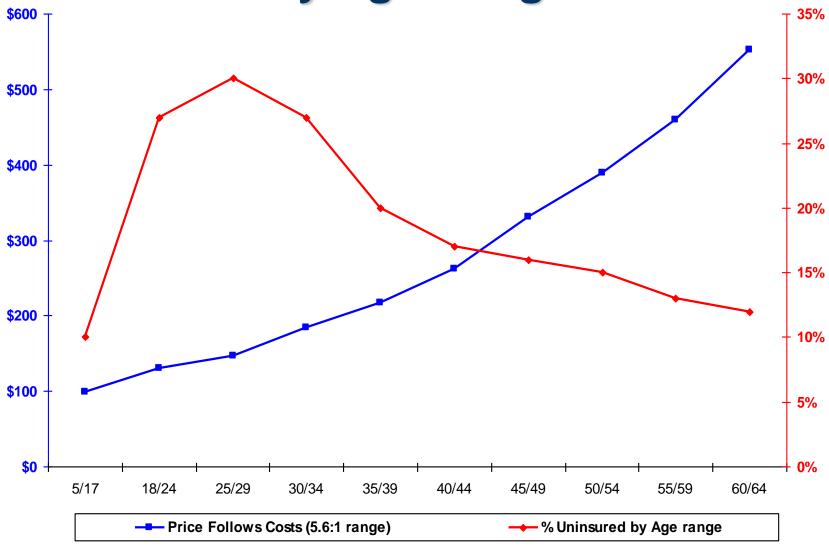
### **Income by Age - South Carolina**



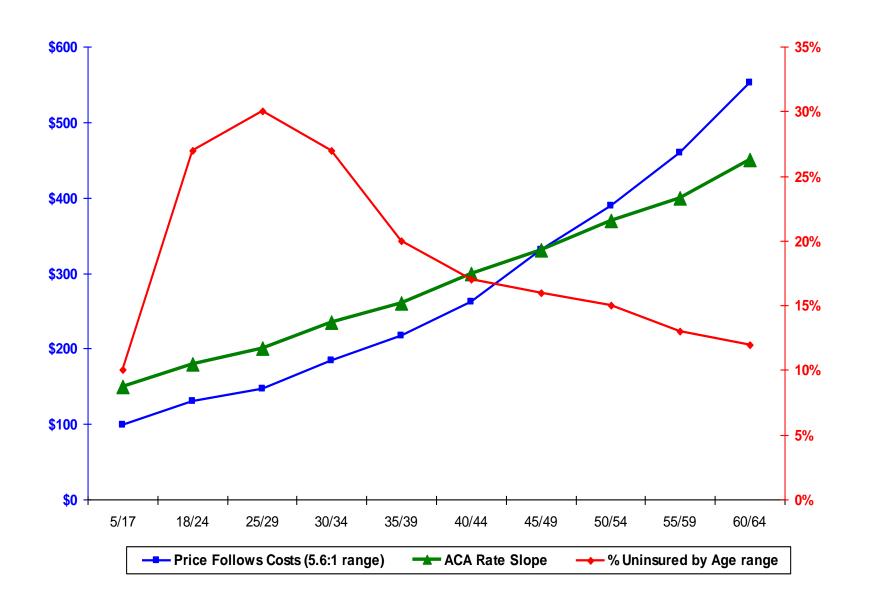
Source: American Community Survey (ACS) 2006-2008



Current Price vs. % Uninsured by Age Range



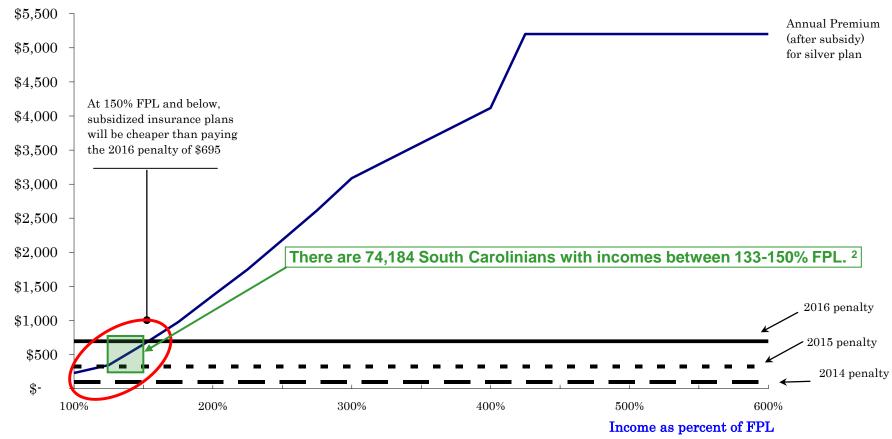
### **Affordable Care Act Rate Compression**



### The Tipping Point for Insurance Purchase

Individuals between 133-150% FPL will be more likely to purchase insurance given that subsidized insurance will be cheaper than paying the penalty





 $<sup>{</sup>f 1}$  Based on Patient Protection and Affordable Care Act; applies sliding scale of 3.0 - 9.5%

 $<sup>{\</sup>bf 2}\,$  Census, American Community Survey Data, 2006-2008

## Individual Exchange: Process for Cost-Sharing Subsidies and Risk Modification

Preliminary process subject to change based on actual regulations

### Consumer Application

- Consumer visits Exchange website
  - Uses calculator to estimate coverage costs
  - Estimate includes possible premium tax credits and cost sharing reductions
- Consumer selects plan
- Consumer applies for premium tax credit and costsharing subsidy
  - Cost-sharing reduction tied to Silver level coverage
- HHS to develop single form allowing application to subsidized Exchange-based coverage, Medicaid or CHIP

#### **Eligibility Review**

- Exchange receives application and passes information to HHS for verification
- HHS verifies income, citizenship and immigration status through consultation with other agencies (e.g., Treasury)
- HHS may verify other information or delegate responsibility to Exchange
- HHS notifies Exchange, insurer and Treasury of applicant's eligibility for cost-sharing reductions

### Periodic Payment to Insurer

- Treasury makes advance payment to insurer
- HHS may establish capitated system with risk adjustment
- Could be similar to Part D payment process

### Insurer Adjusts Cost-Sharing

- Additional actuarial (AV) beyond 70% for baseline silver coverage
  - 94% AV for 100-150% FPL
  - 87% AV for 150-200% FPL
  - 73% AV for 200-250% FPL
- Does not specify combination of deductibles, copayments and coinsurance
- Maximum out-of-pocket (OOP) spending limits based off of HSA limits of \$5,950/\$11,900 (2010)
- OOP HSA limits reduced by:
  - 2/3 for 100-200% FPL
  - 1/2 for 200-300% FPL
  - 1/3 for 300-400% FPL
- Cost-sharing reductions only apply to "essential health benefits"

## Individual Exchange: Process for Cost-Sharing Subsidies and Risk Modification

#### **Risk Adjustment**

#### Transitional Reinsurance

#### **Risk Corridors**

#### MLR

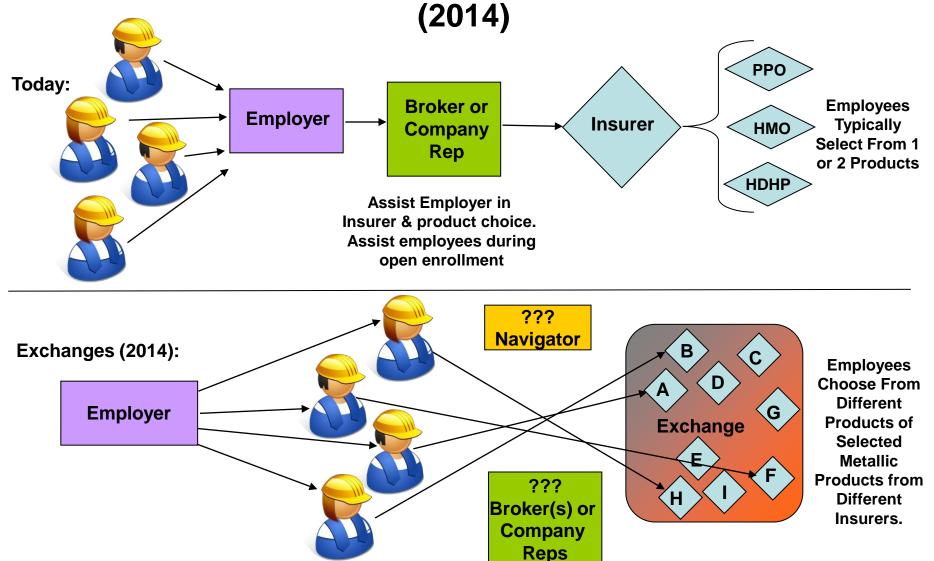
- Mandatory program to be developed by HHS
- Exchange to develop risk adjusters
- Each individual is assigned a risk adjustment
- Premiums to insurers are modified based on aggregate covered individuals
- Function similar to current Medicare Advantage risk adjustment

- Mandatory program for 1<sup>st</sup> three (3) years in individual exchange only
- HHS must design reinsurance program
- Funding from all segments including ASO
- Program administered by non-profits
- High risk individuals identified in advance
- Payment method to be determined by HHS

- Mandatory program for QHPs for 1st three (3) years
- Administered by HHS
- Adjusted for reinsurance and risk adjustment
- Profits over 3% are shared with HHS
- Losses over 3% are shared with HHS

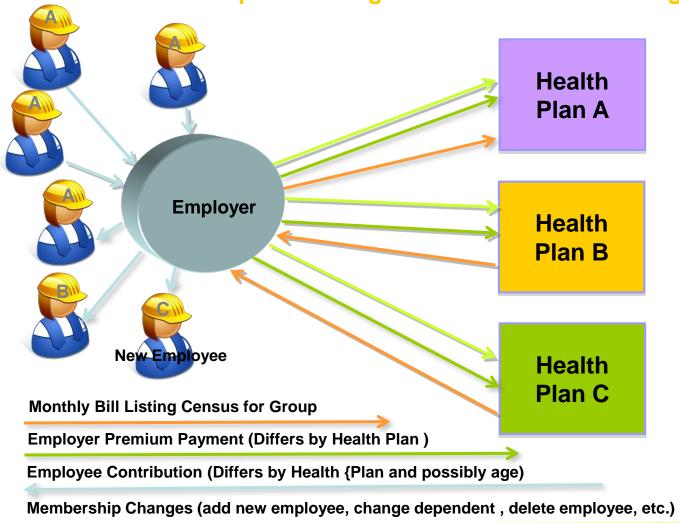
- 80% Individual
- 80% Small Group
- 85% Large Group
- Uncertain how other risk adjustment approaches will impact MLR

Exchanges: Potential Changes to How Small Employers (and Their Employees) Buy Coverage (2014)



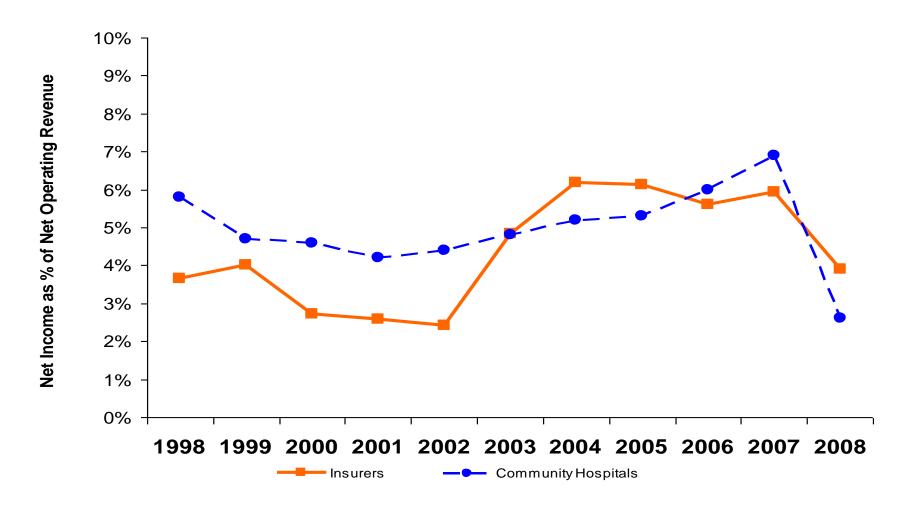
#### **Small Employer Administrative Complexity**

**Membership and Billing Transactions for Exchange Enrollees** 



Dealing with multiple health plans will complicate health insurance administration for the small group market

# Profit Margins for For-Profit Insurers and Hospitals



Source: Commercial Insurers' Average is the annual average of the 5 largest commercial insurers, calculated using 10-K statements from the SEC. Community Hospital Margins are from the AHA Trendwatch Chartbook 2009, "Trends Affecting Hospitals and Health Systems", Table 4.1, Appendix 4, pg. A-32.